From the GMS Committee

Professor Court explains

Report from the chairman

The first meeting of the working party on the hospital practitioner grade had taken place on 10 March, Dr R A Keable-Elliott told the General Medical Services Committee on 17 March. He hoped that because of the progress made there would only need to be one more meeting. According to the Department of Health 1225 doctors had been recommended by area health authorities for regrading and 655 had been approved by regional authorities. But only 59 hospital practitioners had been appointed. Dr Keable-Elliott said that the Royal College of Surgeons of England and the Faculty of Anaesthetists had apparently decided to lay down their own criteria for appointment to the grade, despite the fact that the existing criteria had been agreed by the Joint Consultants Committee, of which both bodies were constituents.

The negotiators had received the latest reports from the Technical Subcommittee on Inland Revenue returns and had been able to submit their case to the Review Body for an increase in practice expenses from 1 April. At the last negotiating meeting the DHSS had been asked again to remove the postgraduate educational requirements for seniority payments. On average general practitioners attend more than 10 postgraduate sessions a year and the Secretary of State had agreed to consider the request, as he did the plea for the removal of the upper age limit of 72 for seniority allowances. The negotiators were still most concerned about the delay in reaching an agreement on related ancillary staff. The Review Body was interested in the subject and Dr Keable-Elliott had asked them to make some reference in their next report to the difficulty in reaching a solution.

The Secretary of State had replied on the problem of remuneration of trainee general practitioners. After consulting his Government colleagues he had confirmed that the anomaly could not be corrected without infringing the current pay policy. He had agreed that the trainees' pay needed reassessment and had referred to the Departmental inquiry about the level of responsibility and pattern of work of trainees. Reporting this to the Review Body the chairman had reiterated the serious manpower problem so far as GP principals in unrestricted practice were concerned. There had been a smaller increase in the number of trainees between 1975 and 1976 than 1974-5, and the Review Body had been told that in some parts of the country there was already evidence of a lowering of standards among entrants to general practice. The GMSC did not accept the interpretation of the pay policy as it affected trainees because they were participating in a three-year course. Dr Keable-Elliott hoped that the Review Body would be able to recommend that trainees should at least continue to receive the same level of remuneration when transferring from one part of their training to another.

- *UEMO draft directives*
- *Support for BMA-linked insurance scheme*
- *Ethical responsibilities of doctors*

EEC: UEMO draft declarations

The chairman of the Committee on the EEC, Dr A J Rowe, told the committee about UEMO declarations on the free choice of a doctor and on medical secrecy in relation to the use of modern methods of communication (data banks) in medicine. He also spoke about his note on the freedom of diagnosis and treatment by the doctor. Dr Rowe had stated that the doctor should have complete freedom, within the limits of the resources available to him, to make diagnoses and prescribe necessary treatment in the best interests of his patient. He should be concerned in all decisions relating to acquiring equipment and engaging personnel connected with the diagnostic and therapeutic processes where he was not the sole employer.

Some members were concerned about the declaration on the free choice of a doctor. Dr Arnold Elliott pointed out that there was no mention of continuing care and Dr W Keith Davidson commented that while there appeared to be a free choice of doctor by the patient, there seemed to be little in the way of free choice of patient by the doctor. Dr Rowe replied that the rights of patients and those of doctors were clearly laid down in the Declaration of Nuremburg, which covered the freedom of the doctor to choose the patient. He undertook to report back the committee's comments.

Professor S D M Court and Dr R Harvard Davis attended the meeting and answered many questions on the report, *Fit for the Future*, which they and their colleagues on the Committee on Child Health Services had prepared. The GMSC is awaiting the comments of its working party, chaired by Dr Arnold Elliott, before debating the report.

Professor Court recalled that his committee's brief had been to review the health service for children up to and through school life and to make recommendations. All concerned, he said, wished to start the journey towards an integrated health service for children as soon as possible, but this aim would not be achieved

In debate . . .

Court Report

". . . *it is estimated that at present there are about a million children with psychiatric disorders and there are 188 child psychiatrists to deal with them. Clearly, there must be an increase in child psychiatrists, which will take time. However, there will never be enough to deal with the problem and it is necessary for trained general practitioner paediatricians and others to do what they can . . .*"

PROFESSOR S D M COURT
(chairman of Court Committee)

". . . *there is no suggestion that general practitioners who are not GPPs should in fact give up seeing children . . .*"

DR R HARVARD DAVIS
(general practitioner on Court Committee)

in less than 15 years. There were 13 million children under 16, who formed a quarter of the total population. They could not speak for themselves. There was still a lot of acute illness and injury and doctors were increasingly concerned about the failure of fetal growth and continuing hazards of birth. The main need was to strengthen primary health care for children—to make it comprehensive and to extend it into medical and social education. By "comprehensive," his committee had meant the unity of prevention and treatment in the same group of people.

Knowledge of child and paediatric care was advancing so rapidly that his committee had doubted whether its application at an acceptable standard could be achieved through the existing pattern of general practice. So it had proposed that one member of a practice, while remaining a general practitioner, should develop a special interest in child health. He would be called a general practitioner paediatrician (GPP). As to support care, there was a need for a variant of the consultant paediatrician: a consultant community paediatrician, was needed. He would work in the community as well as in the hospital, working closely with general practitioners and GPPs in practice premises and health centres, as well as in normal and special schools. He would require greater skills in the care of the handicapped and in educational medicine.

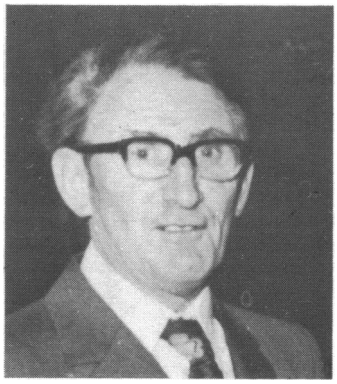
TRAINING

Dr Hubert Jones wanted to know about the qualifying criteria. Vocational training would, Professor Court answered, be mandatory in 1980: three years plus the preregistration year making four years. Perhaps 18 months might be spent in paediatrics: four months in hospital, four months in child health and school health, and the remainder in the teaching general practice environment.

The chairman thought that Professor Court had put forward an attractive concept, but asked him whether he could imagine general practice without looking after children. Had the committee considered the reaction of general practitioners who would not become GPPs? Dr Harvard Davis replied that there was no suggestion that general practitioners who were not GPPs should give up seeing children.

ACCOUNTABILITY

There was a danger, Dr J G Ball thought, of losing the most important part of the present service—single accountability. There was a feeling of intrusion into GPs' work. Why had the committee not extended the present paediatrician rather than put in a fresh one, he asked. Professor Court said that he did not like the word "intrusion." The committee had seen the GPP as not dealing primarily with the everyday care of children, but as adding something to general practice which was often lacking. The committee had not suggested that all paediatricians should do the work because it wanted an identifiable person who would be responsible for developing an undeveloped area. Dr Harvard Davis agreed that there was no wish to interfere with the clinical accountability of a doctor to his patient but there was accountability to the social services departments and departments of education. He drew an analogy with an



Professor S D M Court

industrial medical officer. He had clinical accountability to the people he treated and he also had a contract with the firm for which he worked.

ONGOING RESPONSIBILITY

Referring to the job of the "child health practitioner" in relation to treatment, Professor Court said that it had caused concern to the committee and to the clinical medical officers. They had accepted that it was professionally unsatisfactory for a qualified doctor to be forbidden to treat a patient but they had also accepted that when somebody was treated it was not a once and for all event but an ongoing responsibility.

Dr Lionel Kopelowitz asked Professor Court for his priorities in the recommendations. So far as child psychiatric disorders were concerned, how much of those would be dealt with in general practice and how much by the child psychiatric service? Professor Court emphasised that the committee's primary recommendation was that of strengthening primary care. As to psychosocial disorders, it was estimated that at present there were about a million children with psychiatric disorders and 188 child psychiatrists. The number of psychiatrists would have to be increased, but there would never be sufficient and it was necessary for trained GPs and others to do what they could.

Many general practitioners, Dr W G A Riddle pointed out, thought that it was their duty to treat the family. It now seemed that a special body of GPs was to be created to do paediatrics. He asked whether in a few years' time the Royal College of Psychiatrists would say that there should be general practitioner psychiatrists with special training, followed by a demand for general practitioner geriatricians. Ultimately there would be no general practitioners in the true sense and patients would have to choose the sort of specialist they wanted to see without being advised by the family doctor. Professor Court wondered whether those who maintained that they wanted to treat the family were in fact wholly capable of doing so in 1977, or whether they would be able to do so in 1997, because of the advances in knowledge. The term GPP might disappear if there was an increase in knowledge and skill. And in Dr Harvard Davis's view, the age when the doctor should have total care of his patients had almost disappeared. It was now team work. A practitioner could have total responsibility, but how often did he bring in other people? If he did not, how economically was he using his own skills and time?

The chairman of the Education Subcommittee, Dr George Swift, asked what training needs were visualised in the vocational training of the ordinary general practitioner who would still be doing his ordinary paediatrics. Professor Court told him that he had always been unhappy about undergraduate training of doctors in family medicine and primary care. He had tried to bring family medicine into the undergraduate curriculum. He was unable to answer the chairman's question about whether GP trainers who were taking on trainees to become GPPs would have to be GPPs themselves.

Dr G R Outwin suggested that, by promoting paediatrics within vocational training, it might lead to a state of affairs in which most general practitioners raised the overall standard of health care in a balanced way, rather than by creating the new concept of a GP paediatrician. Dr A A Clark could not see where a "specialoid" would get his patients from if he were in a two- or four-man practice.

Professor Court concluded by emphasising the need for more consultant paediatric help in general practice. At present there were only 393 paediatricians for 13 million children.

Indemnity insurance scheme for BMA members

The committee considered detailed proposals by C T Bowring Professional Indemnity Ltd for the introduction of an indemnity insurance scheme for BMA members. The proposals are based on a system of differential rates; the rate quoted for general practitioners' annual premium at present is £29 pa.

RECOMMENDATION

After a discussion on the proposals Dr J H Marks formally proposed: "That the General Medical Services Committee recommends to the Council that the indemnity insurance scheme outlined in Appendix VII to the GMS Agenda be accepted." He reminded the committee that its first duty was to protect the interests of general practitioners. At a special conference in February 1973 the GMSC had been instructed to maintain the LMC/Conference/GMSC structure within the BMA—"no effort should be spared to this end." That meant, he said, that the committee had to help strengthen the BMA and increase its membership. A general practitioner's loyalty was to the BMA not to a defence body, but the BMA had not been attracting members because it did not deliver the goods. It did too much for free riders. Bowrings was a public company of the highest repute in the insurance world and acted for the Law Society and the accountants. It might be that the high risk people did not join the BMA scheme initially but sooner or later the defence bodies' premiums would have to go up so that they would have to join the BMA scheme. "I do not believe in a closed shop," he said, "but I do believe in people joining." He believed that the Bowring scheme presented a case which was unanswerable: it should be accepted in the interests of the profession, the BMA, and general practitioners.

Dr W G A Riddle seconded the motion. The committee had a duty to pursue the matter. There was no doubt that the BMA

In debate . . .

Indemnity scheme

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DR J H MARKS (Boreham Wood)

". . . *I am opposed to the scheme. Doctors do not join a professional organisation for insurance but for what it can do for their pay and terms and conditions of service. It is no good offering bribes . . .*"

DR ARNOLD ELLIOTT (Ilford)

was under attack. The splinter organisations should be destroyed and their members brought back into the BMA. The scheme gave the BMA an opportunity to do this. If the committee passed the motion it was not passing an Act of Parliament but if it had to go to the ARM this year's graduates would be missed. He reported that Bowring had agreed to accept responsibility for a claim on an incident which occurred before a doctor changed from an existing defence body.

AMENDMENT

Dr J S Happel and Dr F G Tomlins proposed an amendment: "The BMA should offer indemnity insurance to its members but before the scheme is implemented there should be further discussions with the defence bodies." Dr Happel was concerned that the MDU had not been consulted. The defence bodies which offered overlapping services with the BMA and the GMC had never had the pressure put on them in the same way as had happened to the GMC or the BMA.

According to Dr J S Noble, the BMA and commerce did not always mix but collaboration was not always a failure. He believed that indemnity insurance was a proper job for a professional body but if the BMA took on the advice services at present offered by the defence bodies it would mean a lot of extra work. Even so, he hoped that the GMSC would support the scheme provided the negotiations included an adequate exploration of the insurance market.

The retiring chairman of the HJSC, Dr David Wardle, said that he had particular interest in the scheme because it had emanated from the HJSC. Several features made the scheme of paramount importance to the BMA. The scheme was never intended as a cut-price insurance scheme—it was a copper-bottomed scheme backed by reserves and reinsurance. It offered unlimited cover up to £250 000, whereas the existing bodies' cover was "wholly or in part at their discretion."

Dr Arnold Elliott opposed the scheme. Doctors did not join a professional organisation for insurance but for what it could do for their pay and terms and conditions of service. It was no good offering bribes. He pleaded with the committee to be realistic—it would require an army of extra workers if the scheme was introduced. He foresaw that its existence would prompt the same kind of litigation as in the USA with prices rocketing.

Supporting the motion on behalf of younger general practitioners, Dr J D Farrow pointed out that if ever there was concern for BMA membership it was now. As secretary of a BMA division, Dr A E Loden was worried about having to go back and sell the scheme, particularly to consultants. He approved of any scheme which would improve BMA membership but did not approve of going ahead without consulting the whole profession. Dr John Ball said that BMA should not procrastinate any further. It was in the interests of the profession to act now. The BMA had missed the postgraduate boat and it was time to do something tangible.

The amendment by Dr Happel was lost by 32 votes to 11 and the motion carried by 39 votes to 5 with one abstention.

Ethical responsibilities

The discussion document on the ethical responsibilities of doctors working in the NHS (15 January, p 157) had been referred to the standing committees. Dr G W Taylor wanted the committee to spell out what a doctor's ethical responsibility was to his patient. Furthermore, additional machinery for dealing with disputes was unnecessary.

The profession had to make sure, Dr S E Josse pointed out, that the State did not empower doctors to do anything that was unethical such as compulsory sterilisation; in such circumstances it would be ethical to withdraw services. The chairman commented that by limiting the document to the NHS implied that there were different ethics for those who worked outside the NHS. The committee opposed the setting up of new conciliation machinery and agreed to support the following revised paragraph from Dr Taylor:

"In a National Health Service the ethical responsibility of the doctor to his individual patient remains paramount. The profession also has a close concern with the provision of health care to an adequate standard for the community as a whole. It must play a full and active part in the organisation and administration of this care. At the same time it has to be clearly understood that adequate funding of the Service remains the responsibility of the Government; without it the efforts of doctors and others will fail."

Data protection

The Home Office's Data Protection Committee had asked for the BMA's views on the question of ownership of medical records. It had been suggested to the committee that all NHS records were the property of the Secretary of State, who therefore had ultimate control over the disclosure of their contents. It had also been suggested that, in practice, administrators in some areas not only had too much access to records themselves but also had control over access by third parties. Several psychiatrists were said to be concerned about this and about the alleged practice of the police and the Home Office, when denied access to a patient's record by the hospital concerned, of applying to the DHSS. The Data Protection Committee wanted to know whether the BMA agreed that legally, and sometimes in practice, control over NHS medical records lay with administrators rather than doctors; and if so, whether the BMA advocated changing the present position, for example. in relation to legal ownership of records.

The committee decided that a legal opinion should be sought and referred to the General Purposes Subcommittee.

In brief . . .

Fees for part-time medical services

The Price Commission has agreed an increase of 32·27% in those fees for part-time medical services under its control. The increase applies to the Association's recommended fees (category D) as from 1 April 1977. Negotiations are in progress for this increase to be applied also to other fees such as life assurance reports and adoption agency forms. An increase of 50% in fees for attending colliery emergencies has been agreed by the Price Commission and negotiations are in progress with the National Coal Board.

Full details of the new Category D fees can be obtained from the Secretary, BMA House, Tavistock Square, London WC1H 9JP, or from BMA regional offices.

Added years

According to a recent statement by the Secretary of State to the House of Commons, about 100 000 NHS staff have made inquiries about buying added years for an unreduced lump sum under the NHS Superannuation Scheme; 30 000 requests remain to be processed, of which about 12 000 were from doctors. Of the total number outstanding, about 18 000 were firm requests to buy added years and the rest were requests for estimates. The Secretary of State estimated that all outstanding cases, and those generally related to staff who would not reach normal retiring age for 10 years or more, would be cleared by the spring of 1978.

Committee on the EEC

Dr Alan Rowe chaired the Committee on the EEC on 24 March. He told the meeting that at the beginning of March only Denmark, France, and the Irish Republic had introduced amending legislation to give effect to the medical directives. It had been announced in the House of Commons in December that there were still some complex legal issues to be resolved before the Order in Council could be made in the United Kingdom though the General Medical Council had been nominated the competent authority to issue the necessary certificates to UK nationals who wish to practise in another EEC country.